



1. Project Data

Project ID
P152646

Project Name
Emergency Primary Healthcare Restoration

Country
Lebanon

Practice Area(Lead)
Health, Nutrition & Population

L/C/TF Number(s)
TF-18845

Closing Date (Original)
30-Dec-2018

Total Project Cost (USD)
13,672,363.83

Bank Approval Date
19-Mar-2015

Closing Date (Actual)
31-Dec-2019

| | IBRD/IDA (USD) | Grants (USD) |
|---------------------|-----------------------|---------------------|
| Original Commitment | 15,000,000.00 | 15,000,000.00 |
| Revised Commitment | 13,672,363.83 | 13,672,363.83 |
| Actual | 13,672,363.83 | 13,672,363.83 |

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2. Project Objectives and Components

a. Objectives

The objective of the project was to restore access to essential healthcare services for poor Lebanese affected by the influx of Syrian refugees (Grant Agreement p. 5; Project Appraisal Document (PAD), p. 7).

Outcome targets and indicators (but not the project objective) were revised: indicator definitions were revised and output targets were changed in the light of initial implementation delays and progress as of the Mid-Term Review. The change in outcome targets requires that a split evaluation be applied.



b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

Yes

Date of Board Approval

03-Dec-2018

c. Will a split evaluation be undertaken?

Yes

d. Components

Component 1: Provision of the Essential Health Care Services (Appraisal: US\$9.04 million financed from Lebanon Syrian Crises Trust Fund [LSCTF]; additional US\$6 million financed by Ministry of Public Health (MOPH). Actuals: \$8.04 million, MOPH contribution provided in kind as drugs.)

This component aimed to subsidize a package of essential healthcare services to approximately 150,000 of the 340,000 poor Lebanese identified by the National Poverty Targeting Program (NPTP) as living below the poverty line. The NPTP was to use proxy means testing to target the most vulnerable population groups, giving priority to those living in areas most affected by the Syrian refugee crisis. The agreed MOPH (in-kind) contribution was US\$6 million worth of drugs and vaccines for beneficiaries. MOPH would contract Primary Health Care Centers (PHCCs) run by non-governmental organizations (NGOs) to provide defined packages of services for pre- and post-natal care; screening, prevention, and health promotion related to diabetes and hypertension -- the most common non-communicable diseases (NCDs); and general age- and gender-specific screening, prevention, and health education services. The contracts specified a capitation payment, as well as the number of targeted beneficiaries, services in each package, contract value, monitoring, reporting requirements, and payments mechanisms.

Component 2: Readiness and Capacity Building of Primary Health Care Centers (Appraisal: US\$3.17 million financed from LSCTF. Actual: US\$2.95 million).

This component financed scaling-up capacity and preparation of contracted PHCCs. The MOPH used a rapid facility assessment to identify gaps in PHCCs' capacities and resources to meet contract requirements. PHCC capability for implementing the program was to be improved through: (a) technical assistance and skills training for personnel at selected PHCCs through short refresher courses to help them cope with additional patient numbers and immediate needs of beneficiaries; and (b) training in the essential healthcare services guidelines, monitoring and evaluation (M&E), information systems, and relevant software.

Component 3: Project Outreach, Management and Monitoring (Appraisal: US\$1.68 million financed from the LSCTF. Actual: US\$2.68 million).

This component aimed to: (1) ensure effective and efficient administration, regulation, and implementation of the project; (2) improve the effectiveness of the MOPH in contracting with PHCCs; and (3) conduct



rigorous monitoring and performance assessment of the project outputs and objectives. To these ends, it was to finance technical assistance for: (a) providing technical support to the Project Management Unit (PMU) in the MOPH; (b) developing and managing contracts between the MOPH and selected PHCCs and for verifying and validating PHCCs' financial and technical reports for managing the payment process; (c) updating and maintaining a Health Information System (HIS), including providing information technology [IT] hardware and software at the MOPH and links to other agencies involved in the implementation of the project; (d) initiating monitoring and assessment of the project through setting baselines, collecting data, and setting parameters for evaluation; (e) improving the Grievance Redress Mechanism (GRM); and (f) launching an outreach campaign and communication activities to inform beneficiaries about their health rights and services provided at the PHCCs in their areas.

e. **Comments on Project Cost, Financing, Borrower Contribution, and Dates**

Project Costs, Financing, and Borrower Contribution: Total project costs were estimated at appraisal at US\$ 15 million, financed by a grant from the LSCTF, which had been established in December 2013 to assist Lebanon in dealing with the impact of the Syrian conflict, with contributions from numerous donor countries (PAD, p. 19). As noted above, the borrower was expected to contribute \$6 million in kind, in the form of drugs and vaccines to be given directly to providers. The actual spending after the project closed was \$13.67 million, just over 91 percent of the original grant amount. Spending under Component 1 was around US\$1 million less than the anticipated US\$9 million because of delays in releasing funds to the MOPH that affected payments to the service providers. All of the planned activities under component 2 were completed at slightly lower cost than anticipated at appraisal. Under component 3, actual spending was US\$1 million more than estimated at appraisal, because although the outreach campaign and communications activities to inform beneficiary communities about the project were not done, the cost of some of the other activities had been underestimated at appraisal, and many more health facilities than originally planned were linked to the HIS.

Dates: The project was approved on March 19, 2015, and was signed and became effective on July 22, 2015 (ICR, p. 2). A mid-term review was completed in February 2018. The project closed on December 31, 2019, one year later than originally expected, after being extended. There was one (Level 2) restructuring on December 3, 2018. In addition to extending the closing date by one year, the definition of one outcome indicator was revised and definitions of five other indicators clarified, one new corporate results indicator was added, the end targets of one outcome indicator and one intermediate results indicator were revised upwards, and the end targets of two outcome indicators and four intermediate results indicators were revised downwards in the light of progress to date. The objective itself was not changed.

3. Relevance of Objectives

Rationale

The project addressed a pressing problem: access to essential health care in many of Lebanon's poorest areas. The arrival of 1.5 million displaced Syrian refugees had created severe pressure on scarce resources and social services, described in the PAD (pp. 1-3) and ICR (p. 5). Refugees used the same health services as the Lebanese, straining limited supply. This jeopardized the gains that had been made



over the previous decade in increasing access to primary healthcare (PHC) services and free essential drugs, which had contributed to improved health outcomes. Moreover, refugees received subsidized care, while the host population had to pay, mostly out of pocket. Lower income groups were spending an average of 14 percent of their income on health, compared to 4.2 percent for the highest income group (World Bank 2013, Fairness and Accountability: Engaging in Health Systems in MENA, cited in the ICR, p. 5). The refugee crisis increased population dissatisfaction with the healthcare system, and with their high out-of-pocket spending burden.

The **project objective aligned with the government's goals** of improving access to health care and expanding coverage for the uninsured, and expanding coverage for preventive, primary, and ambulatory care, with a special focus on the poor and underserved Lebanese population. In the previous decade, Lebanon had been able to provide uninsured citizens (about 1.6 million people) with inpatient care coverage through contracted public and private hospitals and limited in-kind contributions of drugs and vaccines to PHCCs. However, there were significant coverage gaps in preventive care, and in primary and ambulatory healthcare, with the poor bearing a high financial burden. The project aimed to help address these gaps and help Lebanon cope with the refugees, by providing a package of essential healthcare services comprising preventive, primary, and ambulatory care for the poor Lebanese, particularly those affected by the crisis. It also aimed to strengthen government systems for providing primary and ambulatory care coverage to uninsured and poor Lebanese.

The project was designed and implemented as an emergency operation, and as a small pilot, with a short time frame of three years. The immediate goal was to restore access to essential health care services for poor Lebanese affected by the influx of Syrian refugees to pre-crisis utilization rates. The longer-term goal was to help lay a foundation for progress to Universal Health Coverage (UHC) by: (a) targeting low-income households with a package of care that could be expanded in the future to cover the entire Lebanese population; (b) focusing on disease prevention through preventive and screening services; and (c) building the capacity of the national PHC system.

The ICR (p. 12) noted that the stakeholder consultation meeting held after project completion affirmed the continued relevance of the objective for Lebanese primary health system development, and highlighted positive impacts of the project: (a) increased financial coverage for poor Lebanese who were unable to pay for health services; (b) increased awareness about the concept and importance of preventive care; and (c) improved quality of health care service delivery.

The project was consistent throughout with the World Bank's assistance strategy in Lebanon. At appraisal, the project directly supported Objective 2d, Improved Delivery of Health Services, of the Country Partnership Framework (CPF) for FY11-14 (Report No. 75814-LB dated July 28, 2010). It remained aligned with the FY17-FY22 CPF (Report No. 94768-LB, June 16, 2016) focused on: (i) scaling up access to, and the quality of, service delivery; and (ii) expanding economic opportunities and increasing human capital. In particular, the CPF gave priority to helping Lebanon mitigate the economic and social impact of the Syria crisis, safeguard development gains, and improve its chances of stability and development prospects. Cross-cutting themes of governance and renewing the social contract aimed to help regain the trust of citizens through social and economic inclusion and enhancing the quality of public services.

Rating

High



4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Restore access to essential healthcare services for poor Lebanese affected by the influx of Syrian refugees (original outcome targets)

Rationale

The theory of change was that supporting the MOPH to become more effective in contracting with PHCCs, and providing funding to contract with PHCCs to provide a package of essential health care services to poor Lebanese families especially in areas of the country where large numbers of Syrian refugees were receiving subsidized access to health care through the same channels, would ameliorate “crowding out” and restore and expand access to care for the poorest 40 percent of the Lebanese population. On the demand side, it was expected that providing highly subsidized packages of preventive and basic care at the participating facilities would increase use of these services. Outreach and communication activities were planned to enhance this demand effect. The quality of care would be improved by giving providers refresher training, health care service guidelines, and drugs and vaccines; and by rigorous monitoring and performance assessment of project outputs and progress towards well-defined targets. These inputs, outputs, and activities were expected to lead to increased ante-natal care visits, more screening for breast cancer, hypertension, and diabetes, and more children being immunized. The expected outcomes were better coverage, utilization, and equity in access; and higher patient satisfaction with a strengthened primary health care system. The longer term goals were that the project lay the foundation for a more effective and efficient care model that could be sustained beyond the crisis and would aim at shifting the current hospital-based care model, to a model based on primary health care, prevention, and outpatient case management (PAD p22). This was expected to establish a sounder basis for progress towards the country’s goal of UHC, which would help create a fairer, more accountable health system, and would contribute to continued improvements in the population’s health status.

Outputs

- 75 PHCCs were contracted to provide the specified package of essential services, and contract payments were transferred in a timely way during most of the project.
- An HIS called the Primary Healthcare Network Information and Communication System (PHENICS) was developed to link participating PHCCs to the MOPH, to serve the needs of the project regarding beneficiary recruitment, PHCC patient management, and data collection and follow-up for the project. This system streamlined information flows from the PHCCs and enabled efficient monitoring, feedback, and payment.
- 1,274 health workers received training on clinical packages, PHENICS, finance and procurement protocols, grievance mechanisms, key performance indicators, infection control, waste management, and other topics relating to the project. Project training modules were repeated for new staff to



mitigate the effect of high staff turnover. Training courses were complemented by on-the-job training by MOPH field coordinators and HIS officers.

- Detailed manuals and protocols were provided to all participating health centers for all aspects of the project including outreach, service package specifications and guidelines, user guides for the HIS, and World Bank procurement guidelines.
- The PMU monitoring team prepared a comprehensive M&E plan with support from the World Bank.
- The planned communication and outreach strategy to inform potential beneficiaries about their health rights and services available at the PHCCs in their area, and that the services would be preventive rather than curative, was not conducted.

Intermediate Results

The project met or exceeded the intermediate results targets for readiness and capacity building of PHCCs. These targets were not revised. As intended, 75 PHCCs were contracted. The original target of providing training to 400 personnel was greatly exceeded: 1,280 health personnel received training. Turnover was high, and training was repeated to cover newly hired staff.

Performance against targets for the intermediate results indicators for volume of the various specific health care services was mixed. The original target of 90 percent of pregnant women receiving at least four antenatal visits was not met; since this indicator was dropped at restructuring, results data were not reported in the ICR. The ICR main text reported that 70 percent of women aged 40 years and above were screened for breast cancer; the MOPH Annex reported 73 percent. This partially met the original 90 percent target. The (unchanged) target for 90 percent of the population 40 years and above to be screened for diabetes mellitus was surpassed, with 97 percent screened. The project gave polio vaccines to 6,369 children under 5 years of age, falling short of the original target of 10,000.

The target for reimbursing facilities for the contracted services within two months was surpassed with payment within one month, although the ICR noted that payments were delayed for six months during 2019 because funds were unavailable during a long delay in the some of the Trust Fund donors and then the government ratifying the project extension (ICR, p. 55).

The original intermediate results target was that 80 percent of grievances be addressed, and a reported 72 percent were addressed.

Outcomes

The core project development objective was met: access was restored to essential healthcare services for poor Lebanese affected by the influx of Syrian refugees. The project enrolled 140,299 poor Lebanese in the program, close to the target of 150,000. This was despite the problems caused by inaccuracies in the NPTP database and delays in payments to the PHCCs in 2019. (The NPTP only began in 2011 and had been developed with support from the World Bank. Households had to apply to be included and complete a questionnaire about their assets, which was then verified by the Ministry of Social Affairs (MOSA). The PHCCs found that many poor families were not on the NPTP.) The number of Lebanese accessing PHCCs increased by 56 percent between the start and end of the project. Although data are not available that compare the percentage of the Lebanese population who were able to access care prior to the



arrival of the Syrian refugees and at the start and end of the project, the TTL stated that the project restored and improved this access (conversation with TTL on 4/27/21).

Women comprised 58 percent of beneficiaries, exceeding the target of 50 percent.

The average number of visits per beneficiary per year did not meet the original target of 2. Over all four years of the project, there were a total of 357,163 visits to PHC centers, an average of 2.6 visits per enrollee (since beneficiaries would have been enrolled for different lengths of time, it is not possible to calculate the average number of visits per year). The ICR reported that there were 1.2 visits per enrollee in 2018, but that this fell to 0.8 visits per enrollee in 2019 (ICR, p. 14). The ICR explained that most enrollees completed their preventive visits in the first two years of project implementation and did not make additional visits in 2019; and that the delays in reimbursement to PHCCs in 2019 reduced visits. Visits per year was included as an indicator because it is simple and easy to collect and can be useful as a crude measure of access to health care, especially in cross-country comparisons. However, it does not capture well the level of care provided under this project. The contracts with PHCCs specified a set of services that had to be provided to each beneficiary depending on the results of an initial screening. For example, if diabetes was diagnosed at the initial screening, then a set of additional tests and other services were required, and payment was conditional upon completion of the package of required services. An indicator for the percent of beneficiaries for whom the full package of services was provided, as well as a list of the services included in each package, would have provided a clearer sense of the care that beneficiaries received. The packages were developed by a team from the American University of Beirut, based on current clinical guidelines in the United States, and set an unusually high standard of care for the primary level, especially in country of Lebanon's level of income and fragility.

The PDO indicator for user/patient satisfaction greatly surpassed the original target of 75 percent. A total of 3,300 beneficiaries were administered the patient satisfaction questionnaire; 95 percent rated their treatment at PHCCs as good or very good, 97 percent rated exchanges with nurses as good or very good, and 94 gave this favorable rating to exchanges with doctors.

Although not captured in the objective or any of the indicators, the project explicitly was "laying the foundation for a more effective and efficient care model sustained beyond the crisis and will aim at shifting the current model which is heavily centered on hospital-based care, to a model based on primary health care, prevention, and outpatient case management" (PAD p22, in discussing sustainability). The project succeeded well in this. The mid-term review Aide Memoire (p. 2) noted that "...significant progress has been made ... to build the systems necessary for the development of the UHC program. Key systems including Financial Management (FM), Monitoring and Evaluation (M&E), procurement, and accreditation are put in place. Based on that, the MOPH successfully structured its partnership with NGOs through transparent transactions, routine M&E, and clear supervision processes, thus contributing to three development impacts: improved governance, increased transparency, and strengthened accountability." The program piloted in the project was improved based on a careful review of the project experience during project implementation, and during preparation and appraisal of a much larger (\$150 million) successor project that rolls out the program country-wide.

Rating
Substantial



OBJECTIVE 1 REVISION 1

Revised Objective

Restore access to essential healthcare services for poor Lebanese affected by the influx of Syrian refugees (revised outcome targets)

Revised Rationale

The theory of change remained the same.

Intermediate Results

Performance against targets for the intermediate results indicators for the volume of the various specific health care services was mixed. The target for the new indicator for prenatal care introduced at restructuring was surpassed: 1,508 pregnant women received at least one ANC visit throughout the course of their pregnancy, more than three times the target of 450 women. The 70 (or 73) percent of women aged 40 years and above screened for breast cancer exceeded the revised target of 40 percent (as noted above, the ICR text and MOPH Annex numbers differ). Polio vaccines given to 6,369 children under 5 years of age was well above the revised target of 4,000.

The revised intermediate results target that 90 percent of grievances be addressed within three days was partially met with 72 percent achieved. A new intermediate results indicator added at restructuring that at least 250 grievances be addressed during the project lifetime was surpassed many fold, with a total of 5,761 grievances addressed.

Outcomes

The number of beneficiaries who received essential health care services through the project surpassed the target for this indicator (added at restructuring): 131,720 against a target of 100,000. The project provided 162,730 service packages: 49,810 birth-to-18 years packages, 51,864 female adult packages, 30,230 male adult packages, 16,984 hypertension packages, 11,851 diabetes packages, and 1,991 pregnancy packages. The distribution of users was 39 percent children, 54 percent adults, and 7 percent elderly.

The average number of visits per beneficiary per year partially achieved the revised target of 1 visit per year. The ICR reported that there were 1.2 visits per enrollee in 2018, exceeding the revised target, but that this fell to 0.8 visits per enrollee in 2019 (ICR, p. 14).

The outcome indicator for user/patient satisfaction (over 90 percent satisfaction on all dimensions, as reported above) surpassed the revised target of 80 percent.

Data Validity

Data on the project results came from the PHENICS. The MOPH IT team gave training and refresher courses for users to ensure high quality data and reporting. The PHC department supported the PMU in performing on-the-ground data quality checks and comparing hard copy medical records to soft copy reports (ICR, p. 59). This helped pinpoint errors and better train healthcare workers on proper data entry and reporting, and



provided confidence in the validity of the data. The project team noted that an independent outside IT company that was hired to help upgrade the financial module was impressed with the quality of the MOPH IT team and the PHENICS (conversation with TTL on 4/27/21).

Questions could be raised about the data on user satisfaction. The ICR reported that field reviews found that only ten percent of a sample of patients were aware of the hotline for reporting grievances (ICR, p. 22). This was offset to some extent because the MOPH made phone calls to 300 project beneficiaries each quarter to verify services reported and ask for feedback on the providers and program (ICR, p. 24). The sampling ensured that beneficiaries were selected from all participating PHCCs. The ICR reported that beneficiaries' expectations were not fully met by the subsidized packages which excluded additional diagnostic tests for abnormal screening results to confirm diagnoses; did not screen for NCDs other than diabetes, hypertension, and breast cancer; and had limited coverage for acute episodes (ICR, p. 24).

Revised Rating
Substantial

OVERALL EFFICACY

Rationale

Overall efficacy is rated as substantial under both the original and revised outcome targets. Most of the original and revised outcome targets were substantially met or surpassed, as were most of the original and revised intermediate results indicators targets. Relatively little weight is given to the indicator for the average number of visits per year because it is a crude measure, especially in the context of the defined packages of services that had to be completed under this project in order for service providers to receive payment as contracted. The rating of substantial is justified when considering that the target numbers of beneficiaries were substantially met or exceeded, patient satisfaction targets were exceeded and were at very high levels, and, more importantly, the project went beyond restoring access to essential care for the poor Lebanese population most affected by the influx of Syrian refugees, to also lay the groundwork for a country-wide program and to increase the focus on preventive care. It is also worth noting the extremely difficult conditions of conflict and political, economic, and social disruption within which the project was implemented (although this is not taken into account in the efficacy rating).

Attribution of results to the project:

Achievements are reported in terms of the number of beneficiaries enrolled and served, and the volume of services provided by the PHCCs that were contracted and paid under the project to enroll the beneficiaries and provide them with specified health care services. Thus all the results measured are plausibly directly attributable to the project. Without the project, although these services might have been available, the beneficiaries would have had to pay out of pocket, and utilization would have been far lower. It is likely that far less screening for diabetes and breast cancer would have been done without the project because demand for screening is very low among poor people who must pay out of pocket for it, and they may not know the potential benefits of being screened.



Overall Efficacy Rating

Substantial

5. Efficiency

Ex-ante analysis of efficiency. The PAD (pp, 24-26) provided a qualitative assessment to justify the project investment: “The project is investing in high impact and most cost-effective interventions pertaining to primary healthcare which are supported significantly and statistically by well-documented evidence on their positive effects on averting maternal and child deaths, and reducing morbidity especially among NCDs. Global evidence from multiple economic evaluations support this assertion through showing a substantial rate of return of similar programs ...” (PAD, p. 24). The Disability-Adjusted Life Years (DALYs) that the project would potentially save were estimated, although the assumption that roughly half of the DALYs attributable to the heart disease, stroke, diabetes, chronic obstructive pulmonary disease, preterm birth complications, congenital anomalies, and lower respiratory infections expected among the beneficiaries (if they reflected national incidence levels) might be averted by the interventions, seem over-optimistic. Valuing each DALY at the national per capita income yielded an estimated economic return of \$31.7 million for the project. The PAD noted additional benefits from improvements to the efficiency of the health system, to equity and well-being of the poor beneficiaries, and to their productivity and earnings as a result of prevention of illness and improved health (PAD, p. 25).

Ex-post analysis of efficiency. The ICR replicated the estimate of cost-effectiveness done at appraisal, using the actual number of beneficiaries, 2018 data on disease prevalence instead of data from 2015, updated disease burden estimates, and 2019 per capita income rather than 2014, and estimated the project economic returns at \$36.6 million (ICR, p. 17). The ICR also estimated the DALYs averted by the project using more precise data, specifically the actual number of cases of breast cancer, hypertension, depression, and diabetes detected through project screening, which were lower than the national prevalence. Fewer than half the number of DALYs averted were estimated using this approach, translating to an economic return of \$13.3 million (ICR, p. 17 and Annex 4). The ICR noted that this was likely an underestimate because of data limitations, and because the analysis focused only on selected disease prevention, excluding “gains from other general consultations and other project gains like improved infrastructure and staff capacity building through trainings provided...” (ICR, p. 18). Even this return would be considered highly cost-effective by World Health Organization Standards based on the cost per DALY averted relative to national income (PAD, p. 18).

The ICR rated the technical efficiency of the project as high because it selected a highly cost-effective package of services, targeted poor Lebanese as the beneficiaries, and had a strong focus on prevention. Providing free health care improved beneficiary health outcomes, enabled greater productivity and earnings, and relieved the burden of out-of-pocket spending on health care. The PAD pointed out that the project’s technical efficiency was enhanced by its use of a results-based approach, and its focus on governance, accountability, management, and expansion of essential healthcare services to the uninsured and the poor. The ICR judged implementation as efficient (ICR, p. 18) because the project achieved its objective within a very limited budget, and completed all activities (except an outreach campaign) despite delays in disbursements of funds at the beginning and last year of the project caused by the time it took for the Cabinet to approve the project and issue a decree accepting the grant, and then to ratify the extension of the project closing date.



Use of the NPTP database, developed by the MOSA to identify poor Lebanese, caused considerable delays and difficulties in enrolling project beneficiaries. Many of the people on the NPTP list could not be located. They had moved, or the incorrect address or name was listed, or some household members were omitted. By the end of 2017, 81,000 direct project beneficiaries had been enrolled compared to the (interim) target of 120,000. In March 2018, the MOSA agreed with the MOPH to generate a supplementary database of around 250,000 beneficiaries for PHCCs to use. This used the same basic approach as the NPTP, but streamlined the process: a simple vulnerability assessment was conducted jointly with the MOSA and PHCCs. In addition, PHCCs were authorized to select up to 20 percent of beneficiaries who were not on either database, but were (a) individuals in households of an assigned NPTP family who had been excluded previously from selection; (b) uninsured Lebanese citizens who had previously shown interest in the project; and (c) families identified as vulnerable by the PHCC based on the knowledge of the community. This approach was successful in increasing enrollment and utilization, and PHCCs were able to reach marginalized people who did not usually seek care; however, at closing, 58 percent of the total enrollment was found to have been "off list."

The project had disbursed just over 91 percent of the grant at closing.

Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

| | Rate Available? | Point value (%) | *Coverage/Scope (%) |
|--------------|-----------------|-----------------|----------------------------------------------|
| Appraisal | | 0 | 0 <input type="checkbox"/> Not Applicable |
| ICR Estimate | | 0 | 0 <input type="checkbox"/> Not Applicable |

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Relevance of objectives is rated High because the project addressed an important development challenge, and aligned with country conditions and with current Bank and government strategy. The achievement of project objectives is rated Substantial, as most of the outcome indicator targets were surpassed or achieved, the results chain was plausible, and attribution was convincing. Efficiency is rated Substantial in light of the cost-benefit analysis, relative efficiency of implementation, and disbursement of most project funds. These ratings point to only minor shortcomings in the project's preparation and implementation, producing an outcome rating of Satisfactory.

a. Outcome Rating

Satisfactory



7. Risk to Development Outcome

There is considerable risk to the development outcome because of the political and economic fragility of Lebanon and in the region. The project achieved its core objective, and demonstrated the need for and the benefits of further expanding the scale and scope of PHC services delivery. The program begun under the project has been continued and expanded under a successor project, the Health Resilience Project (HRP). The HRP aims to increase the capacity and the number of contracted network centers from 75 to 204 and the number of beneficiaries from 350,000 to 925,000 drawn from both displaced Syrians and the Lebanese population. The project was a pilot test of an approach to expanding PHC and provided lessons that enabled improvements incorporated into the HRP, which has country-wide scope. The most important lessons were: (i) the need to invest more in outreach and communication activities to stimulate demand for health services, especially preventive care; (ii) the need to expand the package of services to make it more comprehensive and responsive to the health needs of vulnerable populations affected by conflict; and (iii) the need to invest in the hospital sector also to improve the overall cohesion of services provided as well as the functionality and efficiency of hospital management and operations. These project-specific factors suggest a negligible risk to the project's development outcome, but Lebanon is vulnerable to impact from the continued regional instability and conflict, and to the country's own serious political and economic challenges, as well as the added risk of the impact of Covid-19.

8. Assessment of Bank Performance

a. Quality-at-Entry

The project addressed an important development challenge. It drew on existing analytic work and global experience in selecting priorities, and used national data to target interventions to seven of the top twenty conditions that contributed to Lebanon's disease burden. It was designed and implemented as an emergency operation and as a small pilot with a short time frame. The ICR noted that it responded to the imperative to act quickly in fragile situations to help build confidence in the state's ability to respond to challenging circumstances, as noted in the World Bank World Development Report of 2011 (ICR, p. 31). Although primarily focused on the emergency health care needs of poor Lebanese whose health service access had been affected by the influx of refugees, the project was designed to test an approach to expanding access to subsidized essential health care that would also improve governance, accountability, management, and equity, helping Lebanon progress toward UHC.

Despite the short time within which the project was prepared and appraised (the Project Identification Document was dated December 2014, and the project was appraised and approved in March 2015), and although the ICR stated that the team did not have time to conduct a full appraisal, the details in the PAD indicate a well-prepared and well appraised project. The project had clear focus. The logic of the results chain was clear, and the activities were appropriately selected to achieve the project objective. The project design was simple, with three clear, well-structured components. The risks were identified and described in detail in the PAD (pp. 22-23), and reasonable measures were identified and planned to mitigate them.



The Results Framework selected a generally well-chosen set of indicators to monitor project outputs and progress towards the objective. The number of indicators was manageable. The PAD outlined sound M&E arrangements, including detailed plans for verification of the data input into the HIS and quarterly contacting of a sample of patients to verify the services reports and assess user satisfaction and impact.

The ICR noted that “use of the NPTP database for beneficiaries targeting seemed to be the only avenue at the design stage. The Bank team assumed an active role between the MOPH and MOSA to set the specifics of monitoring the reliability of the NPTP database throughout implementation” (ICR, p. 31). It was a newly developed database, and it was reasonable to expect it to be fairly accurate.

The provider payment system used a capitation payment in which providers were paid \$60 per enrollee, of which 20 percent was paid upon enrollment, 40 percent after a first clinic visit, 30 percent after a second visit, and a final 10 percent at the end of the project, conditional on patient satisfaction (ICR, p. 56, Annex 5: Borrower’s Comments). The project team explained that the third payment required providers to have completed the services specified in the clinical packages (conversation with TTL on 4/27/21). It is usual to provide an annual capitation payment, and common that the payment amount be adjusted for gender and age, and perhaps for other factors that tend to correlate with the cost of care, notably existing health conditions. The system used in the project derived the amount per beneficiary on the basis of estimates of the cost of the defined services in each package, and the expected “case mix” based on existing data on prevalence in the population of diabetes, hypertension, and breast cancer, and the expected age group composition of the beneficiaries (young people generally have substantially lower costs of care than older people who are at far greater risk for NCDs). The system did not include payment adjustments based on the actual case-mix or composition of beneficiaries, which meant that providers bore the financial risk if their enrollees had a higher average total cost of care than \$60. The project team explained that the design of the payment system was constrained by the very limited project budget (conversation with TTL on 4/27/21).

Quality-at-Entry Rating

Satisfactory

b. Quality of supervision

The ICR stated (p. 26) that “throughout implementation, the Bank team remained proactive and responsive, provided hands-on support, and continued its efforts in the provision of technical assistance... The Bank team monitored progress and reported on implementation issues to management regularly through Implementation Status Reports. The Bank team communicated closely with the PMU to highlight issues affecting project performance and these were raised both in aide-memoires and management letters.”

A “Rapid Results Approach” used during the first one hundred days after the project was approved was effective in compensating for the extremely rapid preparation and appraisal of this emergency-response project, and helping MOPH to make rapid implementation progress once project funds were transferred to them. Although no health centers were able to be contracted until after the Ministry of Finance transferred the initial project funds to the MOPH in May 2016, good use was made of this time in preparation and training, which enabled a rapid start to contracting and recruitment of beneficiaries.



There was good continuity in team membership, with the same task team leader throughout, who was based in the region. Formal supervision missions occurred regularly about every six months. Detailed aides-memoire were written, although only four were filed in the World Bank document system (formerly known as Imagebank). The mid-term review took place eight months later than the original date (February 2018 instead of June 2017), but this made sense in light of the delayed start to implementation.

There were minor shortcomings in the quality of supervision:

(1) The ICR noted that the Bank agreed to the request by the PHCCs to recruit beneficiaries not on the NPTP who met agreed criteria (ICR, p. 23), but this was two years after beneficiary enrollment began; the team might have been more proactive in this. At project closure, 58 percent of project beneficiaries were not selected within the NPTP, well above the 20 percent limit agreed during the mid-term review (it is unclear whether the 58 percent includes those selected from the supplementary list developed by the MOSA working with the MOPH). The ICR does not say whether there was any evaluation of the extent to which these beneficiaries met the agreed criteria of need, but the project team explained that people in Lebanon have a very strong preference for seeking health care in the private sector, so likely self-selection by those in need reduces concern that many non-poor families would have enrolled in the program.

(2) The ICR (p. 22) reported that “the downgrade (at project closing) in the rating of component 3 “Project Outreach, Management and Monitoring” was due to the limited outreach activities aiming at enrolling the intended NPTP beneficiaries.” The downgrading of this rating occurred well after the issue was evident.

(3) Officially disclosed ISRs included updated results tables, but their text is limited to the same paragraph on project achievements with minor updates, such as in the number of beneficiaries enrolled, without much mention of important implementation issues such as the difficulties encountered in using the NPTP to identify beneficiaries, or the findings and recommendations of the mid-term review (these details are listed in the additional section in ISRs that is not included in the Officially Disclosed version and of course are discussed in aides-memoire).

The achievements of the project occurred despite the extremely difficult circumstances under which it was developed and implemented. The project team noted that the project was undertaken in a “massively complex” environment: ISIS was being fought just two hours away; there was substantial political upheaval in Lebanon, economic collapse, and extreme shortages of government funds; and a civil war was raging, with car bombs and explosions every week (conversation with TTL on 4/27/21). The regional conflicts, instability, and fragility exacerbated Lebanon’s own difficulties.

Quality of Supervision Rating

Satisfactory

Overall Bank Performance Rating

Satisfactory

9. M&E Design, Implementation, & Utilization



a. M&E Design

M&E design had many positive features. The objective was a strong and straightforward statement of the purpose of the project. The theory of change was sound and clear. A manageable number of simple indicators were chosen to track key project activities and outputs, most of which met the “SMART” criteria (some indicators proved not to be achievable). The results framework included target values for all years of the project, clearly specified data sources and responsibility for data collection, and clear and consistent descriptions of all but one indicator (see next paragraph). The project included plans for third-party monitoring and verification of data, as well as quarterly beneficiary assessment, sampling 300 beneficiaries each quarter, and quarterly quality checklists to verify the quality of services provided by the PHCCs. The M&E arrangements included a steering committee headed by the MOPH Director General to facilitate project implementation, coordinate inter-ministerial policies, and address strategic and policy-level issues that might arise. The project included improvements to the MOPH HIS to better support the monitoring and implementation of the program.

There were minor shortcomings in the M&E design. One indicator was somewhat misaligned with the project design: the original indicator for utilization set the target at an average of 2 visits per year per enrollee. However, the provider payment scheme was based on completion of a defined package of services, many of which are likely to have taken place soon after enrollment. The indicator for the percent of grievances related to delivery of project services that were addressed promptly expected to rely on the grievance database as a source. However, the criteria for being addressed was described as “beneficiaries...feel that their grievances are attended to promptly,” which presumably would have required re-contacting people who had submitted grievances. The indicator was not a good way to capture whether grievances related to systematic problems (such as drug shortages, or problems with getting mammograms) were resolved.

b. M&E Implementation

M&E implementation largely followed the design. Data were collected and progress against the indicators regularly assessed and reported. The training provided and the verification procedures are likely to have helped make the data system and data reliable. Scorecards were incorporated into the M&E design during Implementation. These were shared with all PHCCs, and the ICR states that managers found them useful. Annual evaluations by an independent consultant evaluated project progress and provided data on activities and services in each period.

Several indicators were revised during restructuring: five to reduce the targets (some substantially); the indicator for ante-natal care for pregnant women was changed from a percentage of pregnant women to a number, simplifying measurement; and the indicator for the number of beneficiaries was amended from counting everyone who enrolled to counting only those enrollees who actually received services.

Poor infrastructure stymied efforts by the project to provide internet connectivity for all participating PHCCs, without which patient data could not be entered directly into the HIS, necessitating use of paper records, and resulting in duplicative data recording. The ICR noted that despite the connectivity problems, “the system was effective in collecting and reporting required data. The system was subject to continuous improvements and upgrades for better beneficiary enrollment and patient management at the PHCC level” (ICR, pp. 27-28). However, the ICR also noted that “the PHCC staff used it mainly for data entry which are linked to payments rather than patient management” (ICR, p. 27). The data systems



developed and used for the project have continued to be used and useful, with many additional PHCCs added, and to be added as the successor project expands the program country-wide.

The Steering Committee that was supposed to coordinate inter-ministerial policies and resolve strategic and policy issues did not function at any time during project implementation. It might have helped resolve the delays in release of funds and approval of the restructuring.

c. M&E Utilization

Quarterly reports and dashboards were prepared and disseminated regularly among the entire MOPH team, other stakeholders, and the Bank team, and proved useful for providing feedback and taking corrective actions as needed. The MOPH held semi-annual meetings with field coordinators to evaluate progress, identify problems and propose solutions, and agree on next steps. “Decision making at the central level and in the PHCCs benefited from continuous data analysis and reporting. Utilization and access data were used to guide the daily implementation decisions. PHENICS served as a decision support system at the MOPH. Data collected during implementation were used to inform corrective measures to improve overall project implementation and provided useful guidance during restructuring” (ICR, p. 28).

Two specific examples of changes made during implementation in response to monitoring information are illustrative:

- When PHCCs explained that they knew of poor Lebanese families in their areas who were not included on the NPTP, and that some of the people listed on the NPTP were not able to be located, the MOPH and Bank team worked with MOSA to develop an additional list of qualified beneficiaries, and also agreed that 20 percent of beneficiaries could be enrolled who were not on either list, so long as they met the project criteria of being Lebanese, uninsured, and poor. The strong preference for seeking care from private sector providers in Lebanon (conversation with TTL on 4/27/21) suggests that project enrollees are highly likely to have been self-targeting from among the poor. High and increasing levels of poverty in Lebanon also reduce concern that the project included enrollees not in the target group (in 2018, about one third of Lebanon's population were poor (World Bank data), with many more living close to the poverty line).
- Enrollment procedures were streamlined during the project in response to feedback from PHCCs. For example, only one family member, and not all, were required to be present in person at enrollment.

Project M&E provided useful information that informed the design of the follow-on project. Specifically, the provider payment system was improved in several ways: (i) the capitated payment for the packages of services included adjustments for age and gender; (ii) an additional component was related to diagnoses of NCDs and for maternal packages; and (iii) a supplementary component was added for additional outpatient diagnostic tests and consultations, subject to an annual cost ceiling.

M&E Quality Rating

Substantial



10. Other Issues

a. Safeguards

No environmental safeguards were triggered in the project, which was classified as category C. Environmental and social risks were rated as Low during project appraisal.

The project had a positive social impact by restoring access to needed essential healthcare for poor Lebanese citizens who had been most affected by the arrival of Syrian refugees. This demonstrated the ability of the government to provide a key social service. Immunization, prenatal care, and screening and treatment for prevalent NCDs was likely to improve health outcomes, enabling better productivity and earnings. Providing access to health care with only a modest enrollment fee helped relieve the burden of out-of-pocket payment for those health care services.

The grievance mechanism established under the project was “consistent with international good practice, ... adequately budgeted and well-staffed at the national level... Data collection, treatment and resolution of complaints, and timely feedback to citizens/beneficiaries are effective and follow a clear process at the national level. Multiple well-coordinated channels for making complaints are available; hotline, mobile app, MOPH website and emails at the central level (mid-term review aide-memoire, p. 3). However, the MOPH and the PHCCs failed to inform beneficiaries adequately about the GRM, which limited its value. The ICR reported (p. 29) that there were 5,761 grievances in total related to delivery of project benefits. Seventy-two percent of the grievances were reported to have been addressed within three days, compared to a target of 90 percent. The top three grievances were: costs and billing (for services outside the relevant package), resource availability (specifically drugs), and the attitude of PHCC staff, all difficult systemic issues.

b. Fiduciary Compliance

The ICR (p29-30) noted that FM staffing and arrangements were adequate despite initial difficulty recruiting a project Financial Officer, and such a long delay in recruiting an IT firm to develop an electronic financial accounting system (finally contracted in the last year of the project) that the system customization had not been completed by project closing. The PMU had to use manual recording of financial data and excel sheets to produce financial reports and financial statements. However, the project was simple enough to make this unproblematic.

The project FM team mastered Bank FM procedures and successfully prepared and submitted all needed withdrawal applications, financial statements, annual budget plans, etc. The ICR noted that “some inconsistencies were observed between the data generated from (the existing HIS) and the records kept manually” (p. 29) but did not comment on whether these were minor or more serious.

In the first and final years of the project, funds transferred by the Bank were stuck in the treasury account in the Ministry of Finance before being transferred to the project account, which caused delays in project activities.



Interim Unaudited Financial Reports were submitted on time and found to be acceptable. Project Financial Statements were audited by an independent external auditor and found acceptable to the Bank. There were no overdue audits and all had unqualified "clean" auditor's opinions. (ICR, p290-30).

All unused funds remaining in the project bank account at the MOPH or at the treasury account at the Ministry of Finance were refunded to the Bank.

Procurement performance was rated Satisfactory until being downgraded to Moderately Unsatisfactory six months before the end of the project (ICR, p29-30, also the source for the remainder of this paragraph). Until then, procurement documentation and decisions had reflected transparent processes with only minor corrections needed. Good records had been kept and no substantiated complaints from bidders reported. The PMU staff was fully trained on Bank procurement guidelines and on managing and monitoring procurement in a decentralized way. The Bank's Systematic Tracking of Exchanges in Procurement (STEP) was used to store procurement documents, track transactions, and populate the procurement plan. All 75 PHCCs were trained on procurement, and the HIS facilitated procurement-related transactions between the PHCCs and the MOPH.

The TTL explained (conversation with TTL) that the yearly Post Procurement Review for 2018 began with one consultancy contract sampled from the 12 issued that year. When it was found to be unsatisfactory, eight more contracts were reviewed, with a total value of close to US\$1 million. Shortcomings were noted in: (a) publication of awarded contracts; (b) the use of STEP; and (c) lack of transparency in selection of consultancy contracts. Notably, the review found major deviations in evaluating and awarding three consultancy contracts to a firm that did not meet the minimum requirements in the Terms of Reference and Evaluation Reports. The MOPH provided unsatisfactory explanations to the Bank team, and formal requests for clarification were unanswered. The Bank team also noticed that one PMU staff had a potential Conflict of Interest (CoI) and asked that all PMU staff be required to sign CoI certifications, consistent with Bank procedures. This was never done despite repeated requests and reminders from the Bank team.

c. Unintended impacts (Positive or Negative)

Although the primary intended beneficiaries of the project were poor Lebanese citizens whose access to services had been negatively affected by the large influx of Syrian refugees, the Syrian refugees also benefited from the increased service delivery capacity at the PHCCs. The number of Syrians visiting PHCCs increased by 78 percent between the start and end of the project.

The institutional strengthening impact of the project extended well beyond the participating PHCCs. PHENICS was launched in 2016. By the end of the project, 189 PHCCs were using the system: all 75 project centers and 114 non-project centers. PHENICS included modules for electronic medical records, procurement, monitoring, enrollment and outreach, referrals, stock management, and lab results/X-ray results/drugs. The system enabled automation of payment procedures and fiduciary functions in the MOPH. The project team considers PHENICS one of the most important outputs of the project.

d. Other



11. Ratings

| Ratings | ICR | IEG | Reason for Disagreements/Comment |
|------------------|--------------|--------------|----------------------------------|
| Outcome | Satisfactory | Satisfactory | |
| Bank Performance | Satisfactory | Satisfactory | |
| Quality of M&E | Substantial | Substantial | |
| Quality of ICR | --- | Substantial | |

12. Lessons

The first two lessons presented here are drawn from the ICR, pp. 32-33, and restated by IEG. The other two emerged from the information in the ICR.

- 1. In emergency situations, temporary support to meet essential health needs through integrated, pro-poor interventions can mitigate the potential for social instability.** Improving access for a host population by increasing the supply of services and reducing their cost to achieve a better situation than before the refugees arrived can decrease grievances against the refugees, reduce problems with social cohesion, and increase trust in the government. This impact is enhanced if the program improves government accountability and citizen engagement, in addition to the primary benefits of improving health care and health outcomes and reducing out-of-pocket burdens, as in this project.
- 2. Building on existing initiatives and delivery mechanisms can facilitate quick preparation and implementation.** Reliance on existing programs, structures, and tested implementation approaches can help facilitate rapid and effective disbursement and response to a crisis. The MOPH built on its experience in contracting with PHCCs and improved the contract specifications, monitoring, and verification under the project. The project used the existing MOSA mechanism for identifying the poor, and worked with the MOSA to rapidly develop a supplementary list of eligible potential beneficiaries when the existing list was found to be incomplete and to contain inaccuracies.
- 3. Early meaningful engagement with beneficiaries can provide important input into the design of a package of essential health care services.** Engagement with beneficiaries can help ensure that a limited package of essential health care services does not have important omissions that undermine its efficacy and make it unresponsive to the health needs of the target population. Although this early engagement did not happen in the project, beneficiary engagement during the project provided this important input for the design of care packages in the successor project.
- 4. Outreach and communication activities are important to stimulate demand when trying to shift health care seeking behavior to include more prevention.** The need for and value of preventive services (like screening for hypertension, diabetes, and cancers) may not be evident to the intended beneficiaries, so education and skillful social marketing can increase uptake. The successor project has given more emphasis to outreach, communication, and explanation of the value and benefits of prevention.



13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR was clear and thorough. It provided a comprehensive account of the project context, design, restructuring, implementation, and results. The theory of change was logical and well developed. The ICR described some shortcomings in the project, and presented details and data to support comments. It mostly followed guidelines (exceptions noted below). The lessons and recommendations were thoughtfully selected.

The ICR did not use a split evaluation, despite the reduction in several outcome targets during restructuring. It gave insufficient explanations of the project's challenges and shortcomings. For example, it mentioned but did not explain why no communication outreach was done, despite the clear need to explain to beneficiaries the rationale for the focus on prevention of NCDs. Although the mid-term review aide-memoire discussed a need to improve PHCC performance, notably the need to standardize criteria for beneficiary selection, improve clinical practices and capacity, and resolve referral bottlenecks that were causing discontinuation of care, these issues were not adequately discussed in the ICR.

There was no discussion of the reliability of the data on project results. The ICR did not discuss whether or the extent to which results were likely to be attributable to the project, in particular, whether other donors also supporting some or all of the participating PHHCs. The ICR did not comment on the (minor) shortcomings in the choice of indicators - notably that the indicator for the number of patient visits was not a very good measure of utilization of services. Annex 1 Table B provided only cursory information on project activities and outputs. The table in ICR Annex 3 had the wrong numbers in the second two columns. The column headed "Actual at Project Closing" contained the original project costs and not the actual numbers at closing. The "Percentage of Approval" column should have shown these actual disbursement numbers as a percent of the approved amounts.

The ICR was written during the early months of the COVID pandemic and strict lockdown. This prevented the ICR author from spending any time in Lebanon, and greatly limited the ability to talk with project stakeholders, who were dealing with the additional stress and demands of COVID.

a. Quality of ICR Rating Substantial

